CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

CHAPTER IV

INTRODUCTION

The Department of Medical Assistance Services (DMAS) is the state agency responsible for the administration of Virginia's Medicaid Program. Of the programs available through Virginia Medicaid are a group of services referred to as Long-Term Services and Supports (LTSS). These services support individuals in a variety of settings including home, community and nursing facilities. The purpose of Medicaid funded LTSS is to provide medically necessary services and assist the individual to be as independent for as long as possible in the individual's choice of setting (home and community-based or nursing facility).

Frequently Used Acronyms

Emergency regulations (12 VAC 30-60-300 et seq.) became effective on September 1, 2016 related to the process for screening individuals for LTSS. These regulations defined terms, specified timeframes and reporting requirements for entities conducting screenings for LTSS. See the link for access to the emergency regulation: http://register.dls.virginia.gov/vol32/iss23/v32i23.pdf

The following acronyms are used throughout the emergency regulation and as well as this manual chapter.

CBT – Community-Based Teams
Commonwealth Coordinated Care Plus (CCC Plus)
DMAS – Department of Medical Assistance Services
DBHDS – Department of Behavioral Health and Developmental Services
LDH – Local Department of Health
LDSS – Local department of social services
LOC – Level of care
LSH – Long-stay hospital
LTSS – Long-term services and supports
NF – Nursing facility
POC – Plan of care
SCS – Specialized Care Services
SE – Screening entity (refers to CBT, LDH, or a DMAS contractor)
VDH – Virginia Department of Health

Legal Basis

The Code of Virginia §32.1-330 requires that all individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility (NF) services. DMAS shall require a "preadmission screening" referred to hereafter as "screening" of all individuals who, at the time of application to a certified NF (skilled and regular) are eligible for Medicaid or will become eligible within six months.

The Virginia Administrative Code (12VAC30-60-303) defines the criteria for which an individual needs the level of care (LOC) for LTSS. Prior to admission to a NF, the NF shall review the completed screening forms to ensure that appropriate NF admission criteria have been documented (12VAC30-60-308). The VAC requires that NF use the Minimum Data Set (MDS), a federal form, to review and document on an ongoing basis that the individual continues to meet NF criteria.

Role of Medicaid as Payer

The Virginia Department of Health (VDH) licenses nursing facilities (NFs) and certified NFs for Medicare, Medicaid, Medicare/Medicaid (DUAL) payments. Information about the VDH Office of Licensure and Certification is located at:

http://www.vdh.virginia.gov/OLC/

Medicaid adopts the federal Resident Assessment Instrument (RAI) process required for Medicare reimbursement for use in Virginia's certification of Medicaid beds and reimbursement for services to individuals receiving LTSS residing in those beds. DMAS serves as the *payer* for services to individuals qualifying for LTSS in NFs.

There are components that a NF must consider to achieve allowable Medicaid reimbursement.

- Provider Participation Requirements - The NF must meet provider participation requirements for Virginia's Medicaid Program. Chapter II explains the requirements and process for enrollment as a provider of Medicaid services.

- Member Eligibility - Each individual must meet member eligibility requirements that are defined in Chapter III of this provider manual. Member eligibility is determined by the local department of social services (LDSS) in the jurisdiction where the individual resides.

- Covered Services and Limitations - Each individual and provider must meet the criteria defined for each program. This chapter, Chapter IV, includes NF services that are covered by Medicaid and limitations to those services.

- Billing – Each service is reimbursed through the submission of a claim by the service provider. Chapter V of this manual describes the billing instructions for achieving Medicaid reimbursement.

- Utilization Review and Control – DMAS must assure that all federal and state requirements are met; this is referred to as the standards established and methods used to assure high quality care. Chapter VI of this manual explains the utilization and control process to assure proper reimbursement for NF services.

Commonwealth Coordinated Care (CCC) and Commonwealth Coordinated Care (CCC) Plus Managed Care Program

The Commonwealth Coordinated Care (CCC) program is a comprehensive initiative to coordinate care for individuals who are currently receiving services through both Medicare and Medicaid and meet certain eligibility requirements. The program is designed to be Virginia's single program to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports focused on the individual's needs and preferences. The CCC managed care organizations (MCOs) may require prior authorization for NF placement and services; all level of care entries, authorizations and reimbursement for CCC members are performed by the CCC MCO. Additional information on the CCC Program can be accessed at: http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx.

The CCC Plus Managed Care Program is a new managed long term services and supports (LTSS) program. This mandatory Medicaid managed care program will serve individuals with disabilities and complex care needs.

Target Population –

1. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible), including members enrolled in Commonwealth Coordinated Care (CCC). CCC members will transition as of January 1, 2018.
2. Individuals who receive Medicaid long term services and supports (LTSS) in a facility or the CCC Plus Waiver except Alzheimer's Assisted Living waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD)

waivers, will enroll for their non-waiver services only. At this time, their DD waiver services will continue to be covered through Medicaid fee-for-service.

3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals currently enrolled in the Medallion 3.0 program. These members will transition as of January 1, 2018.

This section relates only to individuals enrolled in the CCC Plus Managed Care Program:

CCC Plus Managed Care Program does not change the initial screening process for individuals seeking LTSS. including NF services. Upon completion of the screening process, the screening team will discuss with the individual the choice between institutional and community-based services. If an individual selects institutional care, admission into a NF, the screening team will forward all screening documentation to the CCC Plus Managed Care Program care coordinator for follow-up with the individual to offer choice of NF service providers. The CCC Plus Managed Care Program care coordinator will enroll the individual into the appropriate level of care to authorize NF services. If the individual is enrolled with an MCO, some services, including NF services, and choice of provider. For additional information regarding the CCC Plus Managed Care Program refer to:

http:www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

Virginia Medicaid Web Portal

The Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS (Family Access to Medical Insurance Security Plan) business via one central location on the Internet. The web portal provides access to Medicaid Memos, Provider Manuals, provider search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete secured transactions such as verifying Medicaid eligibility, service limits and service authorization or by submitting a claim. The Virginia Medicaid Web Portal can be accessed at: www.virginiamedicaid.dmas.virginia.gov

Resident Rights

The Code of Federal Regulations (CFR) Title 42, Chapter IV, Subchapter B, and Part 483 identifies the requirements for states and long-term care facilities. Included in these requirements are the specific rights the individual has to a dignified existence, self-determination, and communication with and access to persons and services inside and

outside the facility. A NF must protect and promote the rights of each individual; **some** key elements are listed below:

- Exercise of rights as an individual and as a citizen or resident of the United States;
- Notice of rights and services including oral and written notice in a language that the individual understands;
- Information regarding the individual's rights to make medical care decisions, including the right to formulate advance directives;
- Notification of changes to the individual's condition or room and roommate;
- Right to be fully informed about treatment including the right to refuse treatment;
- Protection of "resident funds" and accounting for those funds;
- Right to manage personal funds;
- Deposit of personal funds in interest-bearing and non-interest bearing accounts;
- Accountability of records (full accounting);
- Free choice of physician and treatment;
- Participation in planning care and treatment or changes in care and treatment;
- Transfer or discharge including movement within the NF under certain conditions (See "Limits/Non-Compensable Services" in this Chapter for notification, documentation and readmit requirements); and,
- Equal access to quality of care meaning that a NF must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State Plan for Medical Assistance Services for all individuals regardless of the source of payment.

Specific details for compliance with the individual rights federal regulation can be found using the link below:
https://www.ssa.gov/OP_Home/ssact/title19/1919.htm

Medicare / Medicaid Certification

NFs may be certified to admit individuals eligible for Medicare or Medicaid or both. Use the link below for guidance related to certification and the use of the Minimum Data Set (MDS) required by CMS:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

CONTROLS AND ADMISSION PROCESS

Screening

The entrance to Medicaid funded long-term services and supports ((LTSS) in Virginia is through the screening process. The following entities conduct screenings for individuals residing in the Commonwealth:

- Community-based teams (CBTs) composed of staff from LDSS and LHD conduct screening for adults, 18 years of age and older, who reside in the community served by the LDSS.
- LHDs conduct screenings for children up to the age of 18 years who reside in their jurisdiction.
- Hospitals, acute care rehabilitation and rehabilitation units in acute care hospitals conduct screenings for adults and children who are inpatients of the hospital.

CBTs entity must complete the screening within 30 days of the request for a screening. All screening documents are automated; the screening entity enters all documentation into the DMAS Electronic Pre-Admission Screening (ePAS) system or other DMAS approved electronic record system. Upon completion of the screening, if the individual meets the level of care (LOC) criteria for LTSS and chooses NF services, the screening entity will provide a copy of the completed screening packet, including the completed Uniform Assessment Instrument (UAI), to the selected NF. Prior to the individual's admission, the NF shall review the completed screening forms to ensure that appropriate LOC criteria have been documented (12VAC30-60-308). Refer to the Screening Provider Manual for Long-Term Services and Supports at the link below for details of the screening process and for a list of the screening forms to be sent from the screening team to the NF for use in the NF admission process.

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal

Pre-Admission Screening and Annual Resident Review (PASARR) for Individuals with Mental Illness, Intellectual Disability and Related Conditions

NFs are prohibited by federal law from admitting an individual with suspected or known diagnosis of Mental Illness (MI), Intellectual Disability (ID), or a Related Condition (RC) without a PASARR. The Virginia Administrative Code 12VAC-30-140 et seq. also requires PASARR. For new admissions to NFs, the screening entity determines whether an individual seeking admission to a NF may have or has a diagnosis of MI/ID/RC; this first step is referral for a Level I identification. Completion of the Level I identification determines whether the individual needs additional evaluation, referred to as a Level II evaluation to determine appropriate LOC and specialized services. The screening entity refers the individual to the Department of Behavioral Health and Developmental Services'

contractor to complete a Level II evaluation. The outcome of the Level II evaluation is forward to the screening entity and indicates whether or not the individual has MI, ID, or an RC, and if so, the specific services that must be provided to the individual upon admission to the NF. Completion of the Level II process is required prior to NF admission. Title 42 Chapter IV, Subchapter G, Part 483, Sub Part C at the link below provides information about Medicaid PASARR Program:

https://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+G%2FPart+483%2FSubpart+C&oldPath=Title+42%2FChapter+IV%2FSubchapter+G%2FPart+483&isCollapsed=true&selectedYearFrom=2010&ycord=1918

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) coordinates the Level II evaluations through its contractor. For information regarding Virginia's PASARR Program, obtain contact information at the link below:

http://dbhds.virginia.gov/about-dbhds/offices/acute-services-pasrr

Level of Care Criteria

An individual's functional capacity, medical or nursing needs and risk for institutionalization combine to determine when the individual requires long-term services and supports (LTSS) at the level of care (LOC) provided in a NF. Medicaid reimbursement is available to those individuals meeting the LOC criteria upon admission and continuingly thereafter while residing in a NF. The criteria for LOC are defined in the Virginia Administrative Code (12VAC30-60-303) and are found at the link below:

http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section303/

Additional details on the criteria are found in the VAC and in the PAS Provider Manual, Chapter IV:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal

Admission to a Nursing Facility (NF)

Prior to an individual's admission, the NF shall review the completed screening forms to ensure that applicable NF admission criteria have been met and documented (12VAC30-60-308). DMAS will authorize payment to the NF as of the date the individual is both: 1) eligible for Medicaid; and 2) documented to meet the level of care (LOC) for NF placement. The NF is responsible for requesting reimbursement for services to the individual meeting both criteria listed above. See Chapter VI of this manual for the instructions regarding submission of the NF admission package to DMAS for fee for service members.

Appropriate Bed Placement – DMAS cannot pay for care provided to an individual eligible for Medicaid when the individual is not placed in a distinct area of the NF certified to provide Medicaid services. An individual eligible for Medicaid who meets Medicare criteria cannot be required to be placed in a Medicare-certified bed. An individual for whom Medicaid pays the co-pay must also be in a Medicaid-certified bed in order for reimbursement to be received.

Semi-private Room - The Virginia Medicaid Program will pay for semi-private or other accommodations (two or more bed accommodations) unless DMAS determines that a private room is medically necessary.

Information is also available regarding provider rate setting and DMAS' MDS Guidance Document 3.0:

http://dmasva.dmas.virginia.gov/Content_pgs/pr-nursing.aspx

COVERED SERVICES AND LIMITATIONS

Services
The duration, scope, and quality of Nursing Facility (NF) care under the Virginia Medicaid Program must not be of any less or greater duration, scope, or quality than that provided to individuals not receiving state or federal assistance.

Specialized Care Services (SCS) – NF Provider Requirements

NF providing specialized care services (SCS) must meet the following requirements for Medicaid reimbursement:

1) Each NF provider of SCS must be licensed and certified for Medicare and Medicaid by the Virginia Department of Health / Office of Licensure and Certification (VDH/OLC) to provide SCS;

2) Each NF shall have a current signed participation agreement with DMAS as an Intermediate Care Facility (ICF) or Skilled Nursing Home (SNH) and a participation agreement with DMAS to provide NF care and agree to provide care to at least four (4) individuals who meet the specialized care criteria for children/adolescents or adults. (12VAC30-60-40.H)

3) If a resident is in a NF and receiving SCS, no payment of hospice services will be made to the hospice provider. The NF SCS provider is responsible for providing and billing for all services the individual receives. SCS must be preauthorized by the DMAS service authorization contractor prior to the delivery of SCS.

4) NFs providing SCS must be able to provide the following SCS to individuals eligible for Medicaid in need of SCS:

a. In-person physician visits at least once (1) every seven (7) calendar days – The visit must be made by the physician, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

b. Skilled nursing services by a registered nurse (RN) available 24 hours per day;

c. Coordinated multidisciplinary team approach to meet the needs of the resident;

d. Infection control;

e. For individuals under age 21 who require two (2) of three (3) rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five (5) days per week;

f. Ancillary services related to a plan of care;

g. Respiratory therapy services by a licensed board-certified respiratory therapist (for ventilator patients, these services must be available 24 hours per day);

h. Psychological services by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric related to a plan of care;

i. Necessary durable medical equipment (DME) and supplies as required by the plan of care;

j. Nutritional elements as required;

k. A plan to assure that specialized care individuals have the same opportunity to participate in integrated NF activities as other individuals;

l. Nonemergency transportation;

m. Discharge planning; and

n. Family or caregiver training.

Specialized Care Services (SCS) – Criteria for Adults

Adults needing SCS must have long-term health conditions requiring close medical supervision, 24 hour per day licensed nursing care, and specialized services or equipment. The population to receive SCS includes adults requiring mechanical ventilation and individuals with a complex tracheostomy who require comprehensive respiratory therapy services (12VAC30-60-320).

1. The adult must require at a minimum:

a. Physician visits at least once per week. The initial physician visit must be made by the physician and subsequent required physician visits after the initial visit may alternate between visits by the physician and visits by a physician assistant or nurse practitioner.

b. Skilled nursing services 24 hours per day. A registered nurse (RN), whose sole responsibility is to the designated unit, must be assigned to the nursing unit that the resident resides.

c. Respiratory services provided by a licensed board-certified respiratory therapist (these services must be available 24 hours per day).

d. Coordinated multidisciplinary team approach to meet the individual's needs.

2. In addition, the individual must meet one (1) of the following two (2) requirements:

a. Require a mechanical ventilator; **or**

b. Have a complex tracheostomy that meets **all** of the following criteria. The individual must:

(1) Have a tracheostomy, with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;

(2) Require nebulizer treatments followed by chest PT (physiotherapy) at least four (4) times per day or nebulizer treatments at least four (4) times per day, which must be provided by a licensed nurse or licensed respiratory therapist;

(3) Require pulse oximetry monitoring at least every shift due to demonstrated unstable oxygen saturation levels;

(4) Require respiratory assessment and documentation every shift by licensed respiratory therapist or trained nurse;

(5) Have a physician's order for oxygen therapy with documented usage;

(6) Require tracheostomy care at least daily;

(7) Have a physician's order for suctioning as needed; and

(8) Be deemed to be at risk of requiring subsequent mechanical ventilation.

Specialized Care Services (SCS) – Criteria for Pediatric and Adolescents

To be eligible for SCS, the child under the age of 21 must have ongoing health conditions requiring close medical supervision, 24 hours per day licensed nursing supervision, AND specialized services or equipment.

1) The individual must be age 21 or under (12VAC30-60-340) and be a child with at least one (1) of the following:

a. requiring mechanical ventilation

b. with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.)

c. requiring ongoing intravenous medication or intravenous nutrition administration

d. requiring daily dependence on device based respiratory or nutritional support (tracheostomy, gastrostomy, etc.)

e. requiring comprehensive rehabilitative therapy services

f. with terminal illness

2) At a minimum, the care needed by the child must include:

a. Physician visits at least once per week (the initial physician visit must be made by the physician. Subsequent required physician visits after the initial visit may alternate between visits by the physician and visits by a physician assistant or nurse practitioner.)

b. Skilled nursing services 24 hours per day (a RN whose sole responsibility is that nursing unit) must be on the nursing unit on which the child is residing, 24 hours per day.

c. Coordinated multidisciplinary team approach to meet needs of the individual

d. The NF must coordinate with appropriate state and local agencies for the educational and habilitative needs of the child. These services must be age appropriate and appropriate to the cognitive level of the child. Services must also be individualized to meet the specific needs of the child and must be provided in an organized and proactive manner. Services may include, but are not limited to school, active treatment for intellectual disability (ID), habilitative therapies, social skills, and leisure activities. The services must be provided for a total of two (2) hours per day, at a minimum.

3) In addition to item #2 above, the child must meet one of the following requirements:

a. Must require two (2) out of three (3) of the following rehabilitative services: Physical Therapy, Occupational Therapy, Speech-Language pathology services; therapy must be provided at a minimum of six (6) therapy sessions (minimum of 15 minutes per session) per day, five (5) days per week; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

b. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac) kinetic therapy, etc., or

c. Children that require at least one (1) of the following special services:

(1) Ongoing administration of intravenous medications of nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.);

(2) Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(3) Dialysis treatment that is provided within the NF (i.e., peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a skilled nurse or respiratory therapist;

(5) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second or third degree burns covering more than 10% of the body);

(6) Ostomy care requiring services by a licensed nurse;

(7) Care for terminal illness.

4. NFs providing SCS must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care individuals who are under the age of 21.

Ventilators and Associated Supplies

Prior approval by DMAS or MCOs will be required for all ventilators and associated supplies furnished to individuals in NFs who are not residing in a NF that has a contract with DMAS to provide SCS.

For those individuals who reside in a NF that does not have a contract with DMAS to provide SCS, DMAS will pre-authorize and make direct reimbursement to durable medical equipment (DME) vendors for the following items for NF use:

- Ventilator rental;
- Portable back-up suction machine;
- Heated Cascade humidifier system;
- Ventilator circuits;
- Tracheotomy tubes;
- Tracheotomy care kits;
- Tracheotomy dressing;
- Suction machine;
- Suction catheter;
- Sterile water;
- Oxygen and oxygen equipment;
- Manual resuscitator; and
- I.V. pole or other suitable support for circuits.

The reimbursement to the DME vendor for Medicaid fee for service members includes the services, consultation of, and teaching by a respiratory therapist to the NF. Medicaid reimbursement requests for ventilators for individuals expected to be placed in NF that do not have a contract with DMAS for SCS, should be sent to:

Department of Medical Assistance Services
Program Administration Supervisor II
Aging Services Unit / Division of Aging and Disability Services
Fax 804-452-5456 or 804-452-5468

The written request must include:

- The individual's Medicaid number;
- The present location of the individual;
- The proposed NF placement;
- The current medical status;
- A written statement from the attending physician justifying need and including the type of equipment required; and
- An itemized list of equipment required; the rental cost of machine-associated supplies and services; and the name, address, and phone number of the respiratory equipment supplier.

Therapies Provided in Nursing Facilities (NFs)

Outpatient physical rehabilitation – For NFs that have therapist as a part of their staff, this section is not applicable.

DMAS reimburses for outpatient physical rehabilitation therapies provided to individuals residing in an NF. DMAS provides direct reimbursement to enrolled rehabilitation providers for outpatient therapies rendered to individuals residing in NFs. This reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source. In addition, it shall in no way diminish any obligation of the NF to provide its individuals such services, as set forth in any applicable provider agreement. If a physician (or other licensed practitioner) order exists for therapies, therapies must be provided as ordered. Reasonable and necessary administrative costs will be considered under the cost settlement process for the NF.

Physical Therapy (PT)/Occupational Therapy (OT)/Speech-Language Pathology (SLP) – for more information, refer to the DMAS Rehabilitation Provider Manual located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

Hospice

When the individual or the individual's family or legally authorized representative elects the hospice benefit, the individual for the purposes of Medicaid is considered a hospice beneficiary. The hospice provider and NF will initiate an individual-specific contractual agreement to identify a plan of care with the services to be provided by the hospice provider and the NF for that individual. Upon enrollment of the individual into the hospice program, Medicaid makes no further reimbursement to the NF for that individual. Services provided by the NF as identified in the hospice/NF agreement for the individual are billed by the NF to the hospice provider; the hospice provider bills Medicaid and reimburses the NF directly for services based on the hospice/NF agreement.
No payment for hospices services will be made to a hospice provider if the individual requesting hospice services is currently receiving services through NF specialized care services (SCS).

The NF is not required to submit a DMAS-80 form for individuals receiving hospice.

NOTE: For those individuals who are eligible for hospice benefits under Medicare and Medicaid, the hospice provider must bill Medicare. Unless specifically prohibited by statute, the Virginia Medicaid Program is the payer of last resort. In these instances, the routine or continuous home care charges would be billed to Medicare, and the hospice provider would file claims with Medicaid for the NF charges. For individuals who are dually eligible under Medicare and Medicaid, the hospice must bill Medicare for the hospice services, even if the individual is not in a skilled bed, and must bill DMAS for

room and board.

These processes may be different for providers who participate in the CCC Plus network. Refer to your provider contract or guidance from the MCO for compliance audit specifications.

For more information about hospice, refer to the DMAS Hospice Provider Manual located at:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

Refer to the link below for more information about federal requirements related to hospice:
(https://www.ssa.gov/OP_Home/ssact/title19/1905.htm)

Durable Medical Equipment (DME) and Supplies

Refer to the DMAS DME and Supplies Provider Manual located at:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

Therapeutic Leave

A NF bed may be reimbursed by Medicaid during therapeutic leave when the individual's plan of care (POC) provides for such leave and is so noted on the individual's record. Therapeutic leave includes visits with relatives and friends, or admission to a rehabilitation center for up to seven (7) days for an evaluation. It does not include admission to an acute care hospital. Such leave is limited to 18 days in any 12-month period (with no restriction as to the duration or time of leave, except in the case of admission to a rehabilitation center for an evaluation, which is restricted to no more than seven days per evaluation). Therapeutic leave is individual-specific and is counted from the first occurrence of overnight leave that an individual takes. From that date, an individual has 18 days of leave available for the next 365 days. Therapeutic leave days also apply to Intermediate Care Facilities for Individuals with Intellectual Disability (ICF / IID).

If an individual residing in a NF is in a SCS category and that individual wishes to use therapeutic leave described above, the individual must be discharged from NF SCS and admitted to regular NF services. Medicaid reimbursement is not allowable for the SCS rate unless the resident is physically occupying the SCS bed.

Traumatic Brain Injury (TBI)

The Virginia Administrative Code 12VAC30-90-330 provides additional reimbursement for NFs providing services to individuals with TBI.

Pharmacy Services

NFs Without Licensed In-House Pharmacies

These NFs may not include the cost of drugs as an expense item in the Medicaid cost report. Medicaid payment will be made to the pharmacy dispensing the drugs. Therefore, pharmacy charges for legend and non-legend drugs are not to be included in the NFs billing invoices.

Pharmacy services for individuals in NFs are covered by DMAS of the MCOs and paid directly to the pharmacy. NFs with licensed in-house pharmacies must enroll the pharmacy as a Medicaid provider. All billings for drugs must be submitted on the pharmacy invoice. Medical supplies purchased from a pharmacy may be shown on the NF billing invoice as an ancillary charge; pharmacies cannot bill DMAS for medical supplies.

Use the link below to access provider enrollment information and the DMAS Pharmacy Provider Manual:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

Other Compensable Services

Other medical services that are necessary to the health of the individuals are covered if the services are customarily provided by NFs. This includes services provided by the NF, such as laboratory, X-ray, etc. Items or services that would not be included as inpatient hospital services are similarly excluded from NF coverage. For services requiring pre-authorization, all pre-authorization criteria must be met in order for the claim to be paid.

LONG-STAY HOSPTIALS

The Virginia Administrative Code 12VAC30-130-80 et seq. authorizes Medicaid coverage in long-stay hospitals having provider agreements with DMAS. Stays in these LSHs shall be preauthorized by the submission of a completed assessment, a physician certification of the need for LSH placement, and any additional information that justifies intensive services. Periods of care not authorized by DMAS shall not be approved for payment.

The criteria for LSH care is provided in 12VAC30-130-100 at the link below:

http://law.lis.virginia.gov/admincode/title12/agency30/chapter130/

DOCUMENTATION REQUIREMENTS

For NFs, the documentation requirements for ongoing care, periodic assessment and discharge are found in Chapter VI, Utilization Review and Control, of this manual.

Documentation requirements for LSHs are found in 12VAC30-130-110 (see link above).

Change-of-Resident Status

The authorization for Medicaid-funded LTSS shall be rescinded by community-based provider, the NF or DMAS when the individual is determined to no longer meet the criteria for Medicaid-funded LTSS. The individual shall have the right to appeal such rescission decision. The individual shall be responsible for all expenditures made after the date of the rescission decision in the event that rescission is upheld on appeal (12VAC30-60-302). In NFs, the individual's attending physician or the Utilization Review Committee are the responsible entities for ensuring continuing oversight of the individual's LOC status.

There are limits to the time frames for which Medicaid reimbursement can continue when a change in LOC is ordered or recommended. See Chapter VI for more information on required documentation after admission.

INDIVIDUAL FINANCIAL RESPONSIBILITY

Individual's Financial Responsibility

A Medicaid individual's financial responsibility toward his/her cost of care is identified as the patient pay. The patient pay amount must be applied to the cost of LTSS. The balance of the charge for NF care, after the patient pay amount is subtracted from the total charge, is the responsibility of the Virginia Medical Assistance Program up to the rate allowed under the payment system.

Medicaid LTSS providers cannot collect more than the Medicaid rate from a Medicaid individual. When Medicaid eligibility is determined, it is often made retroactive to a time prior to the date that the eligibility decision was made. Federal statutory and regulatory requirements mandate that the NF accept Medicaid reimbursement as payment in full when an individual's Medicaid eligibility begins. Thus, NFs are required to refund any excess payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the individual is determined to be eligible for Medicaid.

The DMAS-225 is the document used by LDSS offices to identify a Medicaid member's eligibility. This form must be on file for all Medicaid individuals. Refer to Chapter II for information on responsible party requirements.

Definition of Patient Pay Adjustment

Federal regulations require that the Virginia Medicaid Program's reimbursement to NFs, ICF/IID, and LSHs be reduced by the amount of the individual's income, less certain deductions (the patient pay amount). One required deduction is an amount "for medical or remedial care not subject to payment by a third party," including necessary medical or remedial care not covered under the Virginia *State Plan for Medical Assistance*. Medicaid uses the patient pay amount to determine the amount of the NF's monthly billing that the patient will pay. Patient pay plus Medicaid contribution equals the amount due to the NF for the individual's care for that month. Refer to Medicaid Memo dated September 25, 2015 for information regarding patient pay amounts on claims.

Usually, the patient pay is set aside in the resident fund for such things as personal items. (Chapter VII describes items that may and may not be charged to the resident fund.) Any excess above that amount is paid to the NF as the individual's share of the cost of care. Medicaid reimburses the balance between the amount of the patient pay and the amount of the per diem allowance for an individual in that NF. Patient pay can be Social Security or other retirement income, an annuity, etc.

The amount of the patient pay is determined by the LDSS office. The Medicaid LTC Communication Form (DMAS-225) is initially completed when the individual is found to be eligible for LTSS. If an individual requires medical services not covered by Medicaid (e.g., dental, eye, or hearing services or transportation costs incurred to receive medical or remedial services not covered by Medicaid), the LDSS office responsible for determining financial eligibility may be requested to prepare a DMAS-225 form (for a specified period of time) that allows for funds normally available for NF care to be available to pay for the non-covered medical services. Such medical services must not be covered by Medicaid or be subject to third-party payment.

When payment for a non-covered service is requested, the patient (his/her representative, agent having Power of Attorney, or the NF) contacts the LDSS office and requests a patient pay adjustment. Patient pay adjustments apply only to individuals having a patient pay obligation.

Patient Pay Adjustment Limitations

A patient pay -adjustment request must always be used as the last source of payment. If the individual has other sources of possible payment (e.g., Medicare, major medical insurance, prescription insurance, dental insurance, etc.), payment must be requested from those other sources first. When the NF submits a request for a -patient pay adjustment, a statement must be included that it has been determined that the service is not covered under any other third-party insurance or that third-party coverage is exhausted or paid to its maximum amount.

Only the cost of medically necessary, individual-specific, customized, or non-covered items or services may be deducted from patient pay. This includes electric, motorized, or customized wheelchairs and other equipment not regularly supplied to individuals as part of the cost of care. Supplies, equipment, or services used in the direct care and treatment of individuals are covered services and must be provided by the NF. These include, but are not limited to, standard wheelchairs, recliners, geriatric chairs, special mattresses, humidifiers, cots, incontinent supplies, and routine podiatry care. The NF is responsible for providing these items and services to individuals; their cost cannot be deducted from patient pay. (Note: Extenuating circumstances will be considered for the provision of podiatry care when the individual has a documented systemic condition that would require the services of a podiatrist. In this case, the NF is not responsible for providing podiatry care.)

In addition, DMAS-225 adjustments may be allowed for medically or remedially necessary services that were incurred prior to Medicaid eligibility and prior to admission to the NF. One example of an expense, for which the patient pay amount may be adjusted, is for unpaid dental expenses or costs related to hearing aids prior to NF admission.

The NF is responsible for monitoring proper care of the individual's medical supplies and equipment. Requests for adjustment made because an item is lost or broken by NF staff must include documentation on the individual's interdisciplinary POC regarding proper care and treatment of the item. When loss or breakage is incurred as a result of NF staff following improper practices, the NF must assume responsibility for replacement of the item. If repeated adjustments are requested for the same repairs or the repair is costly, the NF may be requested to submit its POC. In such cases, DMAS will review the request and determine whether authorization should be made.

Services Not Permitted

Types of services that CANNOT be deducted from patient pay include:

- Medical supplies and equipment that are part of the routine NF care and are included in the Medicaid per diem, such as: diabetic and blood or urine testing strips, bandages, and wound dressing; standard wheelchairs; air or egg-crate mattresses; I.V. treatments; splints; and certain prescription drugs;
- Ted stockings;
- Acupuncture Treatment;
- Massage Therapy;
- Personal care items, such as special soaps and shampoos;
- Physical Therapy;
- Speech Therapy;
- Occupational Therapy; and
- Transportation costs to covered Medicaid services.

PATIENT PAY ADJUSTMENT AUTHORIZATION PROCESS

All requests for adjustments must be submitted by the NF using the DMAS-225 and be mailed directly to the individual's LDSS office. Faxes are not accepted. .

Adjustments Less Than $500

The LDSS has authority to authorize requests for items and services for less than $500. Patient pay adjustments less than $500 will be reimbursed at 100 percent of the provider's charges regardless of the provider's Medicaid enrollment status.

Examples of requests generally less than $500include the following:

- Routine dental care, necessary dentures, and denture repair for individuals 21 years of age and older ;

- Routine eye exams, eyeglasses, and eyeglass repair;
- Hearing aids (when medically necessary), hearing aid batteries, and hearing aid repair;
- Batteries for power wheelchairs or other power mobility items owned by the individual, not to exceed four batteries in a 12-month period;
- Chiropractor Services, except for Medicare individuals (Medicare covers Chiropractor Services, and Medicaid covers the Medicare deductible and co-insurance amounts);
- Dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the individual's physician; and
- Transportation costs incurred to receive medical/remedial services not covered by Medicaid. All non-emergency transportation must be pre-authorized by the appropriate Medicaid transportation broker.

Adjustments $500 or Greater

For requests of $500 or greater, the LDSS worker coordinates with DMAS to secure authorization for the items or services. The request submitted by the NF to the LDSS office for the above items or services must include the following information:

- The individual's correct Medicaid identification number;
- The current physician's orders or standing order for the non-covered service;
- Medical justification for the service being requested;
- The service description;
- Actual cost information;
- Documentation that the individual continues to need the equipment for which a repair, replacement, or battery is requested; and
- A statement of denial or non-coverage by other insurance. The NF must obtain verification that the requested service or item is not-covered by any other source. Either an official denial from a third party carrier or a written statement by the NF staff that the insurance company was contacted, and the item or service is, in fact, non-covered is acceptable. In either case, the statement must include identification of the third party payer(s), the policy number, and the name of the insured, the date that the third party payer was contacted, and the full name of the third-party-payer contact person.

Incomplete requests will be returned by the LDSS to the NF without authorization.

Non-Medicaid Enrolled Providers

Because many of the services received by individuals residing in an NF are from providers not enrolled with Virginia Medicaid, individuals could be balance-billed the difference between what DMAS reimburses and the provider's charges. In the case of Medicaid participating providers, they will be required to accept Medicaid's reimbursement as payment in full and cannot bill the individual. the NF should inform individuals of this requirement when medical or remedial services are medically necessary and, whenever possible, a Medicaid- enrolled provider should be utilized. Once again, this change in reimbursement only applies for services that require approval from DMAS.

Requests for adjustments to patient pay for services or expenses, which exceed $500 must be submitted by the LDSS worker to DMAS. The LDSS worker sends the request and documentation from the NF, along with the patient income and patient pay information, to DMAS for authorization. Faxes are not accepted. The request submitted to DMAS must include:

- The current or most recent patient pay information (DMAS-225);
- The individual's correct Medicaid identification number;
- The current physician's orders (may be a standing order) for a non-covered service (the orders must be signed);
- The written medical justification for the service being requested (see below for specific requirements);
- The service description;
- The provider's usual and customary charges;
- The Minimum Data Sheet (MDS) (for hearing aid, wheelchair, and communication device requests only);
- A statement of denial or non-coverage by other insurance. It is the NF's responsibility to obtain verification that the requested service or item is not covered by any other source. Either an official denial from a third party carrier or a written statement by the NF staff that the insurance company was contacted, and the item or service is in fact non-covered, is acceptable. In either case, the statement must include identification of the third party payer(s), the policy number, and the name of the insured, the date that the third party payer was contacted, and the full name of the third-party-payer contact person.

NOTE: The maximum amount of reimbursement for non-covered medical or remedial goods and services for individuals residing in a NF shall not exceed the higher of the Medicaid or Medicare rate for such goods or services.

Medical documentation provides a visual image of the individual's needs. Documentation for medical justification must include the following:

- The physician's prescription;
- The diagnosis and medical findings that relate to the reason for the request;
- Identification of the individual's functional limitation;
- Identification of the quantity needed, frequency of use, estimated length of use; and
- Identification of how the service will be used in the individual's environment.

For wheelchair and other assistive mobility item requests, medical documentation must describe mobility impairments, postural impairments, cognitive ability, and how the needs were previously met. Requested wheelchair components must be matched to the individual's functional limitations. In addition, wheelchair requests must include a recent evaluation (within the last three months) of the chair by a Physical Therapist or Occupational Therapist.

For communication device requests, medical documentation must also describe the speech limitation; the diagnosis related to the speech limitation and prognosis for improvement; speech therapy interventions; how the communication needs are currently being met; the resident's ability and motivation to use the equipment; and why the particular device was selected. In addition, requests for communication devices must include an evaluation by a Speech Language Pathologist, as well as how training on the use of the device will be provided.
For hearing aids, medical documentation must include a written hearing evaluation and interpretation (i.e., findings and recommendations).

For eyeglasses, medical documentation must include an ophthalmologic or optometric written evaluation. In addition, if the individual has cataracts or has had cataract surgery, this must be identified.

For drugs and biologicals, medical documentation must identify the correct National Drug Code (NDC) and the condition for which the product is being used.

TELEPHONIC PRE-AUTHORIZATION IN EMERGENCIES

DMAS will provide telephonic pre-authorization for medical services that are of an emergency nature (e.g., a dental abscess or a fractured tooth). Information regarding the emergency should be provided to DMAS from the individual's representative or provider. Emergency telephonic authorization should be directed to the DMAS Division of Program Operations (OPS) at, the Payment Processing Unit at 804-692-3250.. DMAS Program OPS will send a written response to the requestor pre-authorizing the patient pay adjustment for the emergency medical condition. The telephonic pre-authorization does not bypass the normal procedures for the DMAS225 adjustment request, nor does it supersede the requirements of the LDSS office or DMAS. Following the telephonic pre-authorization, a copy of DMAS' written response must be attached to a completed DMAS-225 adjustment package that must to be sent to the LDSS office so that final authorization can be made by DMAS.

LIMITS / NON-COMPENSABLE SERVICES

"Sitters" in Nursing Facilities

"Sitter" or Companion Service provided to Medicaid individuals in NFs is not a Medicaid-covered service. Another person or organization may purchase this service on behalf of the resident. This is allowable and not countable as income available to the individual if:

- The service provided by the "sitter" is not part of the NF's usual service;
- The "sitter" is not employed to provide a service that should be part of the nursing care rendered by the NF;
- Payment is made directly to the provider of the service and not to the Medicaid resident or to the NF; and
- The NF maintains on file a statement as to the "sitter" payment being made, its amount, which is making it, and for what service or services.

Otherwise, any money received by the individual or paid to the NF on the individual's behalf must be considered as income and could require an adjustment in the patient pay as recorded on the DMAS-225.

Private Duty Nurses

It should be noted that the services of a Private Duty Nurse or Private Duty Attendant are neither covered nor allowed. Private Duty Nurses, Private Duty Attendants, Registered Nurses, Licensed Practical Nurses (LPNs), or other trained attendants, whose services are restricted to a particular individual by arrangement between the individual or representative and the Private Duty Nurse or Attendant, are not covered or allowed. The NF is required, and the payment structure is computed, to cover the nursing care needs of the individual.

Hospitalized Residents

Medicaid does not pay any NF during the time that an individual is admitted and is an inpatient in an acute care hospital. All individuals and their representatives must be informed prior to the transfer that the individual has the right to be re-admitted at the time of the next available vacancy following the individual's discharge from the hospital. This information must be read and signed by the individual or his/her representative. Families may elect to pay to reserve the NF bed while the individual is hospitalized, but the NF cannot require that the bed be paid in order for the individual to be re-admitted as described above.

Refer to 42 CFR § 483.12(b)(3) for the notification and documentation requirements for admission, transfer and discharge rights. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. A NF must establish and follow a written policy under

which an individual is transferred or discharged and readmitted to the NF. The individual must be re-admitted to the NF immediately upon the first availability of a bed in a semi-private room if the individual 1) requires the services provided by the NF, and 2) is eligible for Medicaid NF services.

A NF may not refuse to readmit an individual whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan for the following reason:

- The individual (at the time of re-admission) has an outstanding payment to the NF for which he/she is responsible in accordance with Medicaid regulations and the NF has not complied with the required 30-day discharge notification requirements. Discharge notification requirements include given individuals appropriate appeal rights as described in the NF Provider Manual, .

The NF is required to conform to the following in order to document its compliance with this requirement:

- Post in a conspicuous place accessible to individuals and families, a notice that individuals must be given an opportunity to be re-admitted to the facility at the time of the next available vacancy;
- Include in the individual's record a statement signed by the individual or his/her representative that he/she has been fully informed of his/her right to be re-admitted and the reasons for failure to afford him/her this right as set forth in this section; and
- Document for each individual discharged the disposition of each individual and the follow-up to ensure re-admission as required. This documentation must be on file at the NF and be made available to DMAS staff on demand. At a minimum, the documentation must include the following:
    - The date of admission to a hospital;
    - The date of discharge from a hospital;
    - The discharge destination;
    - If the discharge destination is different from the pre-admission location, and the reason the individual was not re-admitted when discharged from the hospital;
    - If the individual was placed in another NF or alternate setting following discharge from the hospital, indicate: (1) the dates of follow-up contact to ensure that the individual is offered the next available vacancy, and (2) the date the individual was re-admitted. The offer of the next available vacancy must be made in writing and signed by the individual or his/her representative; and
    - If the individual is not re-admitted at the time of the next vacancy, fully document the reason. If the individual is not re-admitted for a reason other than individual refusal, the NF must notify the individual or his/her

representative in writing. The required notice to Medicaid-Eligible Individuals and an example of a compliance form can be found at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/Provider

When an individual, who has been discharged from the NF, or a relative is contacted by the NF to be offered a vacancy, the offer made by telephone must be followed up with a letter documenting the acceptance or rejection of the offered vacancy. The NF may proceed to fill the vacancy if the individual or his/her relative has verbally refused the vacancy without waiting for the written response from the individual or relative. The purpose of the written follow-up is the NF's protection against accusation that it has not clearly informed the resident or his/her relative of the availability of a vacancy.

Any NF that routinely holds beds for a minimum of 12 days for individuals who are discharged to hospitals may be excused from the documentation requirements for hospitalized recipients. It must, however, submit a letter to DMAS indicating that the facility will reserve the individual's bed whether or not anyone pays for the bed. After the facility letter has been received, a specific waiver of the tracking responsibility will be issued.

AUTHORIZATION OF SERVICES

The receipt of an authorization from DMAS for services that require authorization does not guarantee reimbursement. DMAS reimbursement is contingent upon the continued Medicaid eligibility of the individual and is subject to all DMAS Utilization Review (UR) activities.